BALTIMORE CITY HEALTH DEPARTMENT
RYAN WHITE CARE ACT, TITLE I
QUALITY IMPROVEMENT PROGRAM (QIP)

STANDARDS OF CARE COMPARATIVE ANALYSIS:
CASE MANAGEMENT
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COMPARATIVE ANALYSIS OF CASE MANAGEMENT STANDARDS OF CARE

Section 1. Process

The Baltimore EMA Standards of Care (EMA Standards)[1] related to the delivery of case management services were compared with standards established by four different agencies, each representing a different service area (Table 1). National standards for nursing case management were sought from the Association of Nurses in AIDS Care, American Nurses Association and the National League of Nursing. No case management standards have been established by any of these professional nursing associations.

AGENCY	SERVICE AREA	RATIONALE FOR SELECTION
Boston Public Health Commission/AIDS Program and the AIDS Bureau, Massachusetts Department of Public Health/AIDS Bureau, HIV Case Management Collaborative, *HIV Case Management Standards of Care*, Revised Edition, March 2001.	Boston EMA	▪ Title I EMA ▪ Similar to size of Baltimore City ▪ Noted by HRSA to have quality standards of care. ▪ Standards of care revised in 2001.
Virginia Department of Health, Office of Epidemiology, Division of HIV/STD, *Guidelines for Case Managers Working with Persons Living with HIV/AIDS*, Revised 1998	State of Virginia	▪ Geographic proximity to Baltimore ▪ Title II Standards
National Association of Social Workers, *Standards for Social Work Case Management*, June 1992	National	▪ National standards for guiding social work case management ▪ Professional association for social workers
AIDS Administration, Maryland Department of Health and Mental Hygiene, *Standards of Care for Title II and State-Funded HIV Health Services and Support Services*, January 2000.	State of Maryland	▪ Separate standards of care for the same geographic region are established.

The results of the comparative analysis for three of the four organizations are presented in Table 2. Column 1 outlines the EMA Standard of Care, Column 2 outlines the Massachusetts Standards of Care (MA Standards), Column 3 outlines Virginia's Standards of Care (VDH Standards) and Column 4 outlines the National Association of Social Workers Standards (NASW

[1] Greater Baltimore HIV Health Services Planning Council (2001). *Standards of Care for Health Services and Support Services*. Category: Case Management (ratified 1998), section 11, pp. 1-7.

Standards). Column 5 identifies strengths/weaknesses of the EMA Standards with Column 6 offering recommendations.

Table 3 outlines the comparative analysis between the EMA Standards and Maryland's Title II Program. The tabular format used to present the data is similar to Table 2.

Section 2. Summary of Comparative Analysis

MA, VDH and NASW Standards

The Baltimore EMA Case Management Standards are comprehensive in scope, with a significant amount of detail outlined to guide the provision of services. The differentiation between the various levels of case management as compared to two of the three other standards is striking. The VDH Standards outline a "level of care matrix" which are based on CD4 cell counts, mental health needs, substance abuse and basic needs but no other Standard presented information in such detail. None of the Standards presented Limited or One-Time Intervention in a similar fashion. All of the standards support and reinforce the concept of client involvement, with the case manager serving as the pivotal point of service provision.

With the exception of NASW Standards, time frames for key case management activities were clearly outlined and fairly consistent. The EMA Standards, do not, however, adequately delineate time frames for follow-up on activities such as referrals and contacting clients after the initial plan has been developed. Reasons for closing client files are presented in greater detail in both the MA and VDH Standards.

The level of detail related to licensure and protecting client records is more clearly outlined in the EMA Standards, though confidentiality and release of information was addressed across the board. The MA Standards outlined more extensive requirements related to the professional preparation of case managers, supervisors and oversight of case management services. Under the MA Standards, the signature of a case management supervisor is required for the plan of care. Such a requirement builds monitoring and oversight into the framework of case management services.

It is important to note that none of the Standards adequately outlined expectations related to quality improvement. While the EMA Standard did include a component for quality assurance and clearly outlined the items to review within a case management record, the overall process and plan for a quality improvement program was not outlined.

Title II Standards

As with the other Standards, the levels of case management service are more clearly delineated in the EMA Standards. While levels of need are eluded to in the Title II Standards, definitions for various levels are not defined. For instance, "emergency" need is one level that is identified, but specific activities to address this level of need are not outlined.

Standards related to licensure, training, client rights and responsibilities are fairly consistent. The Title II Standards outline a core set of universal standards that are applicable to all service categories. These standards provide a significant amount of information related to confidentiality, eligibility, record keeping and personnel. The expectation of a quality assurance/improvement program is presented in the Title II Standards as a framework and guide to enhance services.

Section 3. Preliminary Recommendations

Specific recommendations for each Standard are outlined in Tables 2 and 3. While the EMA Standards are quite comprehensive and contain a considerable amount of detail, additional information such as defined time frames for specific activities will assist case managers in guiding service delivery. Actualizing the standards of care can prove to be challenging at times. In an attempt to better implement the standards, in 2000 VDH created a companion guide for their Standards. The guide is designed to be used in conjunction with the standards of care and includes a considerable amount of reality-based discussions about how to implement the standards. It might be helpful to review the companion guide to see if such a tool would be a helpful resource for case managers, especially for those with less experience.

Particular emphasis should be placed on following clients and documenting such interaction and status of needs. It might also be helpful to explore the concept of "preventive monitoring" that has been employed by VDH. Preventive monitoring is the process of keeping track of a client's mental, physical, and social status which could help to identify potential crises in the making. Such an approach might prove to be useful in an EMA where case manager case loads are large and clients are often in crisis.

The NASW Standards, which were last revised in 1992, are clearly designed to be a guide for organizations to develop their own standards of care and corresponding policies and procedures. Despite the broadness of their focus, there are several areas that are addressed in NASW Standards that are not addressed in the EMA Standards, such as professional degree and/or expertise requirements of case managers, and size of case loads. The NASW recommends establishing case load standards with the size of the case load being dependent on the complexity of the clients and the populations being served. Case managers providing intensive case management should carry case loads that are smaller that those providing limited or one-time only services.

Discipline-specific requirements for serving as case managers are not delineated in the EMA Standards but are clearly outlined in the other Standards, including Title II. Development of such guidelines might prove to be quite beneficial for organizations seeking to hire appropriately skilled staff.

The Standard related to quality assurance should be re-focused to address an overall strategy for continuous quality improvement. The level and type of information to review should be maintained, but the process and overall plan should be expanded. Such an approach will be more consistent with HRSA's approach to quality improvement.

Table 2. Comparison between Baltimore EMA's Standards for Case Management and Other Agencies

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
1.0 LEVELS OF CASE MANAGEMENT					
1.1 Intensive					
1.1a Duration of relationship expected to last as long as program expectation.	Case management services should be made available to all who wish for and are in need of services.	VDH developed "Virginia Level of Care Matrix for HIV/AIDS Case management" The levels are intensive, regular, occasional, and minimal. These are based on medical T4 cell counts, mental health needs, substance abuse and basic needs. No time frames or restrictions are identified.	Case management requires the development and maintenance of a therapeutic relationship with the client… No specific time frames are identified.	S: The standard is consistent with the intent of Ryan White funding to provide services through the entire life span of persons with HIV.	None
1.1b Significant involvement in coordinating services to consumer/client and/or family and household members.	It is the case manager's responsibility to follow through on the service plan for the client. This includes advocating for the services on behalf of the client if the client is unable to advocate for his/her own behalf.	Case management is an individual or team assistance provided in partnership with people living with HIV to identify needs and facilitate access to, and utilization of resources required to achieve and maintain the highest level of independence possible.	The primary goal of case management is to optimize client functioning by providing quality services in the most efficient and effective manner to individuals with complex needs….goals are established in conjunction with the client and client's family, when appropriate.	S: Consumer involvement is delineated and is in accordance to the other standards. S: Solicitation of information and advice from clients is essential if case management is to address the real-life dilemmas faced by people with HIV.	None
1.1c. Problem solving spans medical, mental health, substance abuse, social services, and support services. Follow-	Assessment of medical history, financial resources, availability of food, shelter, transportation, support	Assessments focus on gathering sufficient information to determine the client's capacity to meet health, social, and	The case manager advocates on behalf of the plan for needed client resources and services needed to maximize the	S: Identification of problem and development of a plan to resolve the issues are required. Follow-up on referrals is	None

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
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up on referrals required.	systems, legal assistance, and substance use status along with emotional and mental health status are the minimum areas to be covered in the assessment.	personal needs. Acuity assessments are stressed as additional options to assist with assignment of resources for clients.	client's physical. Social, and emotional well being and coordinating and monitoring service delivery.	required.	
1.1d. Consumer/client will receive a minimum of one face-to-face contact per month from case manager. If the consumer/client does not follow through with scheduled appointments, the case manager will initiate contact.	Reassessment should occur on an as needed basis, as determined by the case manager, but at least every six months.	High need consumers will be contacted at least every 30 calendar days.	The case manager conducts a face-to-face comprehensive assessment with each client of the social, financial, and institutional resources …. and the relationship to the principal concerns.	S: The level and type of contact is clearly defined and more detailed than other standards.	None
1.1e. Each consumer will have an initial plan of care written up. This care plan will be arrived at by mutual agreement during the assessment phase of services. The plan must be completed within 2 months of the first interview. Written re-evaluation of the care plan will occur once every six months. The agency shall continue with current client plan for one year if the client's need have not changed.	A plan detailing client goals and objectives based on the needs assessment should be developed collaboratively between the case manager and client. The plan should…include clear time frames and an agreed upon plan for follow-up. Service plans will be completed within 30 days of the initial intake date.	Screening must be completed within 72 hours of initial contact, including by telephone. Intakes must take place within 10 calendar days of the initial screening. Assessments must be conducted within 30 calendar days after intake.	The case manager advocates on behalf of the plan for needed client resources and services needed to maximize the client's physical, social, and emotional well-being and coordinating and monitoring service delivery.	S: Time frames for development and re-evaluation of care plan by level of case management are clearly delineated.	None

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Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
1.2 Intermediate or Periodic					
1.2a Duration of relationship expected to last as long as program expectation.	No time frames or restrictions are identified	Provide consumer access to a consistent link for case management services.	Case management requires the development and maintenance of a therapeutic relationship with the client…. No specific time frames are addressed.	S: The standard is consistent with the intent of Ryan White funding to provide services through the entire life span of person with HIV.	None
1.2b Level of case manager's involvement in coordinating services to the consumer/client and or family and household members will be determined by the consumer's needs for interventions.	Client level intervention and system level interventions are addressed, but not in sufficient detail to compare.	Development of the client service plan is an interactive process between the case manager and the client. Under certain circumstances decision making may be deferred to a representative legally designated by the client, along with the case manager as an advisor, if requested.	Although the roles and responsibilities of individual case managers can vary…case managers perform a range of common tasks related to client level and system-level interventions.	S: The standard ensures that the case manager will be involved in all phases of case management practice to the greatest extent possible.	None
1.2c Problem solving spans medical, mental health, substance abuse, social services, and support services. Follow-up on referrals required.	For clients receiving only information and referral services, the client should be contacted at minimum by phone once every six months to determine if needs have changed.	Keeping track of a client's physical, mental, and social status will allow you to determine and …anticipate newly arising needs	The case manager advocates on behalf of the plan for needed client resources and services needed to maximize the client's physical, social, and emotional well being and coordinating and monitoring service delivery.	S: Identification of problem and development of a plan to resolve the issues are required. S: Follow-up on referrals is required.	None
1.2d Contact will be initiated by the case	Clients receiving all other case management	Less emergent need consumers will be	At all stages of client intervention, the case	S: The level and type of contact is clearly defined	None

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manager or consumer at least every (3) months and at least one face-to-face contact a year.	services must have a completed re-assessment form on file every 6 months.	contacted at least every 30 (optimum), 45 (goal), or 60 (minimum) calendar days.	manager be granted sufficient authority to access, allocate, monitor, and evaluate service and fiscal resources. The direct contact between the case manager and the client is essential to effectively accomplish the assessment and plan development.	and more detailed than other standards.	
1.2e Each consumer will have a written initial plan of care, which will be re-evaluated at least annually.	A plan detailing client goals and objectives based on the needs assessment should be developed collaboratively between the case manager and client. The plan should…include clear time frames and an agreed upon plan for follow-up. Reassessment should occur on an as needed basis, as determined by the case manager, but at least every six months.	Development of the client service plan is an interactive process between the case manager and the client. Service plans include client goals, objectives, an estimated time frame for accomplishing objectives, and action steps necessary to carry out objectives.	The social worker, in concert with the client and his/her family selects and outlines an array of services and interventions for the service plan. Two important aspects of the plan are the client's personal and capacity-building goals. This plan incorporates the client's expectations, choices, and the short and long-term goals to which the client clearly has agreed.	W: Standard 2.6a indicates the plan must be evaluated every six months.	Resolve the discrepancy between the standards of care related to frequency of re-evaluation.
1.3 Limited or One-Time Intervention					
1.3a Clients receive a mini assessment specific to client identified problem; other issues and problems may be identified at this	Separate assessments for Limited or One-Time Interventions are not described.	Acuity assessments are stressed as additional options to assist with assignment of resources for clients.	No separate assessments are addressed.	S: A mechanism to assess needs for clients receiving Limited or One-Time Intervention is established. Such mechanisms are not	None

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point. Intervention is documented.				described in the other standards.	
1.3b Duration of relationship may be limited to specific issues.	No time frames or restrictions are identified.	No time frames or restrictions are identified.	Case management requires the development and maintenance of a therapeutic relationship with the client…. No specific time frames are addressed.	S: Flexibility of length of relationship is afforded based on the specific issues identified.	None
1.3c Problem solving limited to resource identification.	For clients receiving only information and referral services, the client should be contacted at minimum by phone once every six months to determine if needs have changed.	Not addressed.	No limits identified for any case management service.	S: Scope of work related to problem solving has been limited to identification of resources. Specific parameters for 2 of the 3 other standards are not outlined.	None
1.3d Case manager is expected to have no more than 2 contacts. If more follow-ups are necessary within a 90-day period from the initial contact, the case manager will re-assess the level of case management for appropriateness.	Although case managers will determine the extent of follow up, in order for a case to be considered active, case manager contact with the client should occur at a minimum of every 6 months.	Less emergent need consumers will be contacted at least every 30 (optimum), 45 (goal), or 60 (minimum) calendar days. Additional level of specificity for singular or emergent needs is not provided.	No time frames provided.	S: The level of interaction is clearly defined. Similar levels of specificity are not outlined in other standards. W: Depending on how the level of service is communicated with the client, the definition could prevent clients from contacting case managers when there are real issues, if the clients may think they are "bothering" the case manager or not allowed to have more than 2 contacts.	None
1.3e No plan of care is necessary.	No restrictions are identified.	Clients assessed with a singular or emergent need,	No restrictions are identified.	S: The lack of a plan of care reduces paperwork	Outline requirements for documenting services

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		not requiring further attention, may have no service plan developed.		for case mangers. W: Without documentation of issues, resources provided and resolutions, there is no quality assurance process to support this form of case management.	provided.
2.0 PRACTICE GUIDELINES **2.1 Consumer/Client Identification**					
2.1a Screen all individuals to determine HIV status and appropriateness for agency services.	All clients who request or are referred for services will participate in the intake process.	Prospective clients… are screened to determine their eligibility for receiving any services offered by the agency.	The case manager conducts a face-to-face comprehensive assessment …of the social, financial, and institutional resources …. and the relationship to the principal concerns.	S: Meets the legislative requirement for verifying HIV status and income eligibility prior to delivery of services.	None
2.1b Make suitable referrals for persons not appropriate for agency's case management services.	Not addressed.	Not addressed.	... having received referrals…the social worker screens clients' circumstances and resources to determine eligibility and appropriateness for the case management program.	S: Recognizes that case management services may not be appropriate for the client's needs and that other referrals may be needed.	None
2.1c Assess individuals in crisis to determine what agency interventions are appropriate.	Does not specifically identify clients in crisis. All clients who request or are referred for services will participate in the intake process.	Emergency needs are addressed as part of the screening process.	Does not specifically identify clients in crisis. The case manager conducts a face-to-face comprehensive assessment and screens clients' circumstances and	S: Plans to assess persons in crisis are specifically addressed.	Maintain this level of detail in standards of care.

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			resources to determine eligibility and appropriateness for the case management program.		
2.1d Assign a case manager to eligible clients at time of initial contact.	No time frames are specified as to when a case manager is assigned.	Assessment takes place when the intake has been completed and the consumer has been assigned a case manager. Prior to assessment other staff may conduct screening and intake.	A differential use of staff may be implemented in carrying out case management responsibilities, particularly when specialized expertise is indicated.	S: Clients are immediately linked with a case manager at the initial contact. W. Identification of a case manager prior to an intake does not provide an opportunity to match the case manager to the client and their needs.	Allow more flexibility as to when case manager can be assigned, but no later than completion of the intake and screening. Define the time frame for completion of the screening process.
2.2 Intake					
2.2a Agency shall complete an initial assessment on eligible clients at time of intake; collecting all information outlined on agency's intake forms.	Intakes are completed for all clients using a uniform intake form completed by an intake worker prior to assignment to a case manager. This should be completed within 5 days of the client initial contact with the agency.	Screening must be completed within 72 hours of initial contact, including by telephone. Intakes must take place within 10 calendar days of the initial screening.	The case manager conducts a face-to-face comprehensive assessment …of the social, financial, and institutional resources …. and the relationship to the principal concerns.	W: Timeframe for completion of the intake process is not defined.	Define the time frame for completion of the intake process. *Note:* Intake and Psychosocial Needs Assessment/Resource Identification are both labeled Standard 2.2
2.2b Clients presenting with emergency needs will have those needs addressed by conclusion of the intake appointment.	Emergency needs are not addressed separately.	Emergency needs are addressed as part of the screening process.	Emergency needs are not addressed separately.	S: Emergency needs of client are to be handled as priorities.	None
2.2c Client will be seen for first case management appointment within 5	Once a client is assigned to a case manager, contact must be made	Screening must be completed within 72 hours of initial contact, including	No time frames for completion of intakes or assessments are	S: Time frame for initial appointment is consistent with other agencies.	None

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working days after assignment to a case manager or 10 working days if an off-site visit is required.	within 5 working days to set a time for a more thorough assessment. The intake process will be started within 5 days of first client contact with the agency. The entire intake process must be completed within 30 days of the beginning of intake.	by telephone. Intakes must take place within 10 calendar days of the initial screening.	provided.		
2.2d Agency shall assist the client in identifying and making an appointment with a medical provider for those not already connected to a primary medical care provider. *Client is to schedule their own appointment if able.*	A comprehensive assessment of health is addressed as part of the assessment. During the assessment, clients should be assessed for linkages to primary care.	Linking clients…with existing health and psychosocial services …represents the central task of case management. VDH standards address medication adherence.	Linkages to primary care are not specifically addressed, only having resources to meet client needs.	S: Linkages to primary care are specified and directly correspond to the intent of Ryan White CARE Act.	None
2.2 Psychosocial Needs Assessment/Resource Identification					
2.2a Case manager shall complete a comprehensive written psychosocial needs assessment for each client within 30 days or by the conclusion of the 3rd case management visit, whichever comes first. The needs assessment shall include a medical and psychosocial history and shall be included in the	Assessments should occur within 30 days of intake. The assessment will include a minimum of medical history, current health status, emotional and mental health status, substance use status, availability of food, shelter, transportation and financial resources.	Assessments must be conducted within 30 calendar days after intake. Assessments focus on gathering sufficient information to determine the client's capacity to meet health, social and personal needs. Acuity assessments are stressed as additional options to assist with assignment of	O time frames are provided for completion of the biopsychosocial assessment. Areas commonly evaluated by the social worker include mental health, pre-existing health or mental health problems, and an appraisal of support systems.	S: Time frame for completion of assessments is consistent with other standards. S: A comprehensive assessment is consistent with the Ryan White Title I requirements for identifying and meeting client needs.	None *Note:* Intake and Psychosocial Needs Assessment/Resource Identification are both labeled Standard 2.2.

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
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client record.		resources for clients.			
2.2b Case manager shall ensure that client chart contains written indication that current needs have bee discussed and/or identified at time of needs assessment. Case manager should review the listed areas of consumer/client needs when performing needs assessment.	Documentation in the forms of progress notes, updated notes on initial assessment should be in the client's record.	Monitoring and evaluation involve documenting the degree to which services are delivered in a manner consistent with an agreed upon plan. Preventive monitoring is suggested to help control the emotional and financial costs associated with HIV crises.	A uniform method of collecting and reporting assessment findings should be developed for use by all case managers in the agency.	S: Case managers are encouraged to review the identified needs with clients to ensure the information is correct. Documentation of this process clearly communicates the needs identified during intake.	Explore the feasibility of "preventive monitoring" for clients that are continually in crisis in an effort to identify issues prior to be becoming a crisis.
2.2c Agency should ensure that mini-assessment specific to the client-identified problem is completed for any individual requesting limited/one time intervention.	No separate assessments are addressed.	Acuity assessments are stressed as additional options to assist with assignment of resources for clients.	No separate assessments are addressed.	S: A mechanism to assess needs for clients receiving Limited to One-Time Intervention is established. Such mechanisms are not outlined in other standards.	None
2.3 Development of Client Plan of Care					

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.3a Case manager shall, with active participation of client, identify which needs are to be addressed through the development of goals and objectives with established time frames. Incorporate written objectives and goals into the plan of care, which is a permanent part of the client chart. Development of the plan of care started by the 3rd case management visit or within 30 working days after assignment to case manager.	A plan detailing client goals and objectives based on the needs assessment should be developed collaboratively between the case manager and client. The plan should…include clear time frames and an agreed upon plan for follow-up. Service plans will be completed within 30 days of the initial intake date.	Development of the client service plan is an interactive process between the case manager and the client. Service plans include client goals, objectives, an estimated time frame for accomplishing objectives, and action steps necessary to carry out objectives. Service plans must be developed and filed within 30 calendar days of intake.	The social worker, in concert with the client and his/her family selects and outlines an array of services and interventions for the service plan. Two important aspects of the plan are the client's personal and capacity-building goals. This plan incorporates the client's expectations, choices, and the short and long-term goals to which the client clearly has agreed. No time frames are addressed for completion of client plans of care.	S: Emphasis on joint development of goals and objectives for care plans is consistent with other standards. S: Time frame for development of plan of care is consistent with 2 of the 3 standards. S: Within the plan of care, established time frames for completion of goals and objectives are to be established. This is consistent with 2 of the 3 standards.	None
2.3b Agency, together with client, shall identify appropriate resources needed to attain stated goals and objectives. Resources shall be written into plan of care.	It is the case manager's responsibility to follow through on the service plan for the client. Case managers will…advocate for services on behalf of the client… Document progress toward resolution of each item in client's service plan.	Keeping track of a client's physical, mental, and social status will allow you to determine and …anticipate newly arising needs. Preventive monitoring is suggested to help control the emotional and financial costs associated with HIV crises.	The case manager should coordinate service delivery to ensure the continuity and complimentarily of the interventions. The case manager should have frequent contact with providers and clients and document contact in the service plan.	S: Identification of resources is not the sole responsibility of the case manager. Empowerment of the client toward self-sufficiency is a key goal of case management. Having the client identify resources helps to begin that process.	None

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.3c Agency shall provide written verification that client is in agreement or disagreement with goals and objectives contained in plan of care.	Completed service plan signed by the client, case manager, and case management supervisor and in client's record.	The service plan will be implemented when signatures are obtained from the case manager and the consumer or consumer representative.	Whenever possible, the client and or family should sign the service plan to indicate agreement with and participation in the development of the plan.	S: Documentation of client's response to care plan is consistent across all standards.	None
2.4 Implementation and Coordination of Client Plan					
2.4a Case manager will proactively attempt to contact client after the development of the plan to implement those parts that were not executed at the time of plan development. Plan will establish priorities among the identified needs.	It is the case manager's responsibility to follow through on the service plan for the client.	Keeping track of a client's physical, mental, and social status will allow you to determine and …anticipate newly arising needs. Contact and progress or inability to contact or make progress toward agreed upon goals are to be documented…..	The case manager should coordinate service delivery to ensure the continuity and complimentarily of the interventions.	S: Follow-up with clients is outlined. S: Needs will be prioritized in order of importance. W: The time frame for contacting the client is not defined.	Define time frames for contacting clients after care plans have been developed.
2.4b Case manager shall advise the client on making arrangements with service providers selected and on ways of gaining access to those services.	It is the case manager's responsibility to follow through on the service plan for the client. Case managers will act as the liaison between clients and other service providers. This includes being in contact with the referral source about the client and advocating for services on behalf of the client.	The case manager role is to encourage clients to utilize existing resources which best meet their needs.	The case manager must fully disclose the resources that are available and that are unavailable, required copayments, cost-sharing, time limits for service provision, timing and frequency of reassessments…	S: Clients are encouraged to coordinate access to services once they have been provided with appropriate information about resources. W: This standard does not take into account clients who are unable to navigate systems and follow through on assigned tasks.	Include a provision for case managers to access systems for clients who can not successfully access services on their own.

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Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.4c Case manager shall document in writing all referrals and outcomes initiated and or completed as they relate to the plan of care. Any corresponding actions initiated by the client/other identified people and the outcomes resulting from these actions shall be incorporated into the client record.	Document in client's record progress toward resolution of each item in client's service plan. Identify and communicate with other service providers with whom the client may be working.	Contacts and progress will be documented in the progress notes accompanying the service plan via telephone or meeting notes and photocopies of agency generated assistance.	A uniform method of collecting and reporting findings should be developed for use by all case managers in the agency.	S: Written documentation allows any case manager to assist the client with future needs. The standard also allows documentation to be used by other agency staff to support client needs and provides a foundation for quality assurance processes. W: The time frame for follow-up on referrals is not defined.	Define the time frame for follow-up on referrals.

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.4d Case manager shall be in communication with the client as follows: **Intensive:** A minimum 1 contact per month and 1 face to face contact every 6 months. **Intermediate:** A minimum of 1 contact every 3 months or 1 face to face contact every year.	Reassessment should occur on an as needed basis, as determined by the case manager, but at least every six months. For clients receiving only information and referral services, the client should be contacted at minimum by phone one every six months to determine if needs have changed. Clients receiving all other case management services must have a completed reassessment form on file every six months.	High need consumers will be contacted at least every 30 calendar days. Less emergent need consumers will be contacted at least every 30 (optimum), 45 (goal), or 60 (minimum) calendar days.	The collection and documentation of program related data should allow for the aggregation of information on issues such as services needed by clients. No time frames for monitoring are provided.	S: The number of required contacts are clearly defined for intensive and intermediate service. W: The level of contact for Limited services is not defined.	Define the level of contact for limited case management services.
2.5 Monitoring the Client Plan					

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.5a Documentation of the monitoring process shall be recorded in the client record. Monitoring shall occur at a minimum of the following: **Intensive:** A minimum 1 contact per month or 1 face to face contact every 6 months. **Intermediate/periodic:** A minimum of 1 contact every 3 months (1 face to face contact every year). **Limited**: Case manager involved in no more than 2 contacts limited to particular issues.	Reassessment should occur on an as needed basis, as determined by the case manager, but at least every six months. For clients receiving only information and referral services, the client should be contacted at minimum by phone once every six months to determine if needs have changed. Clients receiving all other case management services must have a completed reassessment form on file every six months.	High need consumers will be contacted at least every 30 calendar days. Less emergent need consumers will be contacted at least every 30 (optimum), 45 (goal), or 60 (minimum) calendar days.	The collection and documentation of program related data should allow for the aggregation of information on issues such as services needed by clients. No time frames for monitoring are provided.	S: The frequency of contact and documentation is clearly delineated by level of service. Other standards do not contain this level of specificity. S: Written documentation allows any case manager to assist the client with future needs.	None
2.5a(1) If a client cannot be located after several attempts to reach by telephone and/or letter, for 2 months, then a referral is made to case finding to assist in locating the client.	Document in the record all attempts that were made to reach the client.	If the case manager is unable to locate the consumer after three documented contact attempts and or 6 months, they can be discharged.	Not addressed.	S: Specific parameters define when a client should be referred for case finding. No other standards outline a similar process.	None

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.5a(2) If the client cannot be located within 90 days, the case management record is moved to inactive status.	In order for a case to be considered active, case manager contact should occur at a minimum of every 6 months.	If the case manager is unable to locate the consumer after three documented contact attempts and or 6 months, they can be discharged. Inactive status should not exceed 6 months.	Not addressed.	S: Specific time frames for moving clients to inactive status are outlined. No other standard offers this level of specificity.	None
2.5a(3) At end of year, if there is no contact, then the case management record is closed (intensive and intermediate).	If a case manager is unable to reach the client for a period of 12 months after repeated, documented attempts, the case will be considered closed.	Inactive status should not exceed 6 months. Discharge may occur when a client chooses to discontinue contact, no longer requires case management services, moves from your service area, is noncompliant, exhibits threatening or dangerous behavior to staff or dies.	Termination occurs for a number of reasons, including the client's attainment of stated goals, rehabilitation, client or family noncompliance, the client or case manager's withdrawal , or the client's death.	S: The time frame for closing a file due to lack of contact is clearly delineated. S: Sufficient time is allowed before a record is closed. This allows clients to be reinstated as needed, which is particularly important given the high number of substance users and those with mental health issues.	None
2.5b Case manager shall monitor the services provided and service delivery to verify that services are being received and are sufficient in quality and quantity.	Identify and communicate with other service providers with whom the client may be working.	The case managers ability to regularly monitor clients will depend on their mobility, caseload, and the client's telephone access.	The case manager should have frequent contact with providers and clients to ensure that services are provided as indicated in the service plan and to ascertain whether such services continue to meet the client's needs.	S: An expectation is made that services will be monitored for receipt, quality and quantity. W: The frequency and process for monitoring services are not specified.	Outline the frequency and requirements for monitoring services.

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.5c Case manager shall provide written documentation of any difficulties encountered in achieving the goals and objectives and provide written strategies for resolving these difficulties.	Document in client's record progress toward resolution of each item in client's service plan. Identify and communicate with other service providers with whom the client may be working.	Case manager will document progress or lack of progress toward achieving goals set forth in the service plan.	Not addressed.	S: The required documentation addresses difficulties encountered and strategies taken for resolution. This standard provides a reminder of the importance of consistent documentation for case files.	None
2.5d Case manager shall make available professional supervision or consultation to all case managers while plan of care is being monitored. Minimum of 1 hr. of formal supervision/mo. is required.	Supervisors are responsible for monitoring the work of case managers through records review.	Not addressed.	Professional supervision should be made available to all case managers… Minimum # of hours of supervision are provided based on education level and years of experience. Ex. For the first two years of degree professional experience, at least one hour of supervision should be provided for every 15 hours of direct client level case management tasks.	S: A minimum level of supervision required is clearly outlined. W: The minimum level of supervision may not be sufficient for less experienced case managers. W: Supervision requirements are delineated only while the care plan is being monitored.	Additional supervision requirements should be delineated for case managers with limited experience or education. Supervision requirements should be designated for all phases of the case management process.
2.6 Re-evaluation of the Plan of Care					

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.6a Each agency shall assess the client records a minimum of every 6 months to determine the client's status and progress and whether any revision is needed in the care plan or in the provision of services. Record review in progress notes. Record review may be done by case manager, supervisor, peer review or formal audit.	Extensive detail is provided on case manager supervision requirements. Documentation of the review of revised care plans must be done by the case manager and the supervisor. Supervisors are responsible for monitoring the work of case managers through records review.	Reassessment should take place every 90 calendar days or when conditions or consumer needs arise that must be addressed.	Case documentation and the maintenance of updated concise records also serve to protect the case manager from potential legal problems as well as provide a basis for service planning.	S: The time frame for re-evaluation of the plan of care is defined. This level of specificity is not outlined in 2 of the 3 standards. S: Six months is a reasonable amount of time to resolve client issues, and determine the status of others. W: Standard 1.2e indicates plans for clients receiving intermediate or periodic case management services shall be re-assessed every year.	Resolve the discrepancy b the standards of care relate frequency or re-evaluation.
2.6b The case manager shall develop with the active participation of the client, new goals and objectives if the needs have changed since the previous needs assessment.	Conduct reassessments of client needs on an on-going basis, at a minimum of every 6 months.	A reassessment should tie together the work with a client from the original assessment and work plan through the monitoring of any areas of progress or changes in client status which may have occurred.	The case manager will periodically reassess the client's needs and progress in meeting the objectives… to ensure the timely provision of services.	S: Consumer involvement is expected. Only VDH Standards address this. S: This standard is a reminder for case managers to take a proactive approach to determining client needs.	None
2.7 Closure					

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.7a Prior to closure (with the exception of death), the agency shall attempt to inform the client of the re-entry requirements into the system, and make explicit what case closing means to the client.	The discharge summary will include a reason for the discharge and a transition plan to other services or other provider agencies.	If a case manager is unable to reach the client for a period of 12 months after repeated, documented attempts, the case will be considered closed. The discharge process shall take place face to face, unless not possible.	In some instances the client should be transferred to another suitable case management program to ensure continuity of care.	S: Clients are given the opportunity to return to case management. S: This standard provides a protection for the case manager and the agency against clients who will be unable to remember how, why or when case management services where terminated. This also allows time for reinstatement. W: Requirements for documenting attempts to reach the client are not delineated.	Outline requirements for documenting attempts to reach the client.
2.7b The agency shall close a client file according to the procedures established by the agency.	Discharge may occur when a client chooses to discontinue contact, does not respond to contact attempts, no longer requires case management services, moves from your service area, is noncompliant, exhibits threatening, client's actions put the agency case manager or other clients at risk or dangerous behavior to staff or dies.	Discharge may occur when a client chooses to discontinue contact, no longer requires case management services, moves from your service area, is noncompliant, exhibits threatening or dangerous behavior to staff or dies.	Although an agency will set certain criteria for terminating a case, it is the responsibility of the case manager, client, and significant others to prepare for the effects of termination.	S: Closure of client files are deferred to agency procedures. W: Beyond lack of contact with client and death, examples of reasons for closure of files are not provided. W: Requirements for documenting reasons for closing files are not delineated.	Provide additional examples of reasons for terminating services and closing files. Outline requirements for documenting reasons for closing files.

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
2.7c Adults records must be maintained for a minimum of 10 years after last entry. Records of children under 19 yrs. must be archived until child reaches 24 yrs. or 6 yrs. after death.	Not addressed.	Not addressed.	Not addressed.	S: Record keeping and file maintenance time frames are clearly outlined.	None
3.0 LICENSING					
3.0a Agency will show evidence of being licensed by an appropriate body.	Not addressed.	Not addressed.	Not addressed.	S: Agencies must be licensed by an appropriate body.	None
3.0b Licenses must be current and available.	Not addressed.	Not addressed.	Where required by state law, the case manager should be licensed or certified to practice.	S: Agency licenses must be current.	None
3.0c Where applicable, staff will have licenses that are current and appropriate for providing case management services.	Numbers of years experience, versus degree requirements are addressed. The hiring agency has the discretion to develop a training plan for persons without appropriate experience. Specific licensure requirements are not delineated.	Minimum qualifications: A bachelor's degree or extensive experience in a human service related field such as social work, psychology…skilled in case management and assessment techniques… Specific licensure requirements are not delineated.	The case manager shall have a baccalaureate or graduate degree from a social work program accredited by the Council of Social Work…Where required by state law, the case manager should be licensed or certified to practice.	S: Licensed staff are expected to maintain licensure. W: Discipline-specific requirements for serving as case managers are not delineated nor are standard educational requirements outlined.	Explore the feasibility of designating minimum education requirements or discipline-specific requirements for individuals to serve as case managers.
4.0 TRAINING AND SUPERVISION					

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
4.0a Agency will maintain documentation that demonstrates case management services are provided directly by or under supervision of LCSW and/or RN case manager.	Case managers will receive at least two hours of supervision per month to include client care, case manager job performance, and skill development.	Case management supervisors should have management experience overseeing case management staff….	Professional supervision should be made available to all case managers… Minimum # of hours of supervision are provided based on education level and years of experience. Ex. For the first two years of degree professional experience, at least one hour of supervision should be provided for every 15 hours of direct client level case management tasks.	S: Discipline-specific requirements of supervisor are outlined. W: The years of experience required to serve as a supervisor are not delineated.	Delineate the minimum years of experience required to serve as a supervisor.
4.0b Maintain documentation for staff education, given or taken, on pertinent HIV/AIDS topics.	Not addressed.	Not addressed.	Not addressed.	S: Documentation of continuing education activities are required. W: Minimum training requirements are not outlined.	Outline the annual minimum training requirements.
4.0c Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.	Newly hired case managers will attend MDPH funded training within three months of being hired.	Case managers and supervisors need on-going training and development essential to build staff skills. Agencies are expected to develop and implement agency/consumer tailored in-service training plans.	Each case manager shall assume personal responsibility for continuing professional education. He/she should complete 90 hours of such education every three years in accordance with the NASW standards for continuing education.	S: Continuing education is encouraged and are critical for all staff to remain knowledgeable about HIV-specific issues. W: Minimum training requirements are not outlined.	Outline minimum training requirements.

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
4.0d Create a system that regularly updates staff resource information network of available services for PLWH/A.	Not addressed.	Agencies are expected to develop and implement agency/consumer tailored in-service training plans.	The case manager has a responsibility to participate in community needs assessment, community organization, and resource development to see that the needs of clients are identified and understood and that community action is initiated to meet particular needs.	S: A system to keep staff informed about available resources is expected.	None
5.0 CLIENT RIGHTS AND RESPONSIBILITIES					
5.0a Have a written agency policy on client confidentiality.	Each agency will have a policy pertaining to client confidentiality that is in accordance with state and federal laws	Persons conducting screenings shall have signed a confidentiality statement….Individuals doing intakes shall have signed a confidentiality statement…	All information about a client and the client's family that is obtained by the social worker in carrying out case management tasks shall be held in the strictest confidence. The case manager shall orally restate assurance of confidentiality to the client…	S: Standards is in accordance with HRSA's expectation.	None

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
5.0b Have a statement signed by the client that states the policies were explained. Eligibility criteria and available services should be given to each client requesting services.	All agencies will provide a release of information form describing under what circumstances client information can be released.	The intake worker shall …provide information about…consumer rights and responsibilities, the eligibility requirements to receive financial assistance, and the resources available in the community to meet the consumer needs.	Human service agencies and service delivery settings that provide case management…should develop and disseminate clear policies and guides that cover …who has access to records…information about cases….	S: Client signatures are required. S: Empowerment of clients begins with ensuring they are aware of all policies and procedures for service delivery.	None
5.0c Have a system for ensuring that case records are protected and secured.	Not addressed.	Not addressed.	Human service agencies and service delivery settings that provide case management…should develop and disseminate clear policies and guides that cover …who has access to records…information about cases….plans for retention and disposition of records.	S: A system for ensuring case records are secure is required.	None
5.0d Have a written, signed consent for release of information that pertains to establishing eligibility for agency services.	An up to date release of information form exists for each specific request for information and each request is signed by the client.	The consumer shall be asked to sign releases of information and any other forms required by the agency during the intake.	Information may be released to other professionals and agencies only with the written permission of the client or his/her guardian.	S: Standards are consistent. S: This standards ensures information is not released without client authorization.	None

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
5.0e Have a written grievance procedure.	Each agency will have a policy identifying the steps a client should follow to file a grievance and stating how the grievance will be handled.	Not addressed.	No grievance procedures are addressed.	S: Establishes a formal system for clients to grieve issues. S: Standard is in accordance with HRSA's expectations. W: The key components of a grievance procedure are not outlined.	Outline the key components that should be included in the grievance procedure, e.g. steps to file a grievance, how the grievance will be handled.
5.0f Have a statement of consumer/client rights as well as responsibilities of agency expectations of each client.	Agency policies are to ensure that policies and procedures are in place that protect clients' rights and ensure quality of care.	The intake worker shall …provide information about…consumer rights and responsibilities, the eligibility requirements to receive financial assistance, and the resources available in the community to meet the consumer needs.	The case manager shall ensure the client's rights to privacy and ensure appropriate confidentiality when information about the client is released to others. No reference to client expectations.	S: Standard is in accordance with HRSA's expectations.	None
5.0g Have a statement that outlines process for both voluntary and involuntary disengagement from services.	The discharge summary will include a reason for the discharge. The standard lists 6 criteria for discharges.	Conditions for discharge include: case mgmt. needs met, client transfers locations, administrative discharge, death client self-removal.	…. an agency will set certain criteria for terminating a case…..	S: All policies related to case management should be in writing, including discharge criteria. W: Clients are not required to sign the statement.	Request clients to sign the statement.
6.0 QUALITY ASSURANCE					

Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*
Baltimore EMA Standards	**MA Standards**	**VDH Standards**	**NASW Standards**	**Strengths/Weaknesses**	**Recommendations**
The quality assurance plan, contained in the client file, should include the following: 6.0a A mutually established plan of care. 6.0b A full needs assessment with psychosocial and medical needs described. 6.0c Documentation of services delivered, referrals made, advocacy efforts initiated to address needs as presented in care plan. 6.0d Evidence that the plan of care was reviewed at least 6 months and when appropriate modified according to the medical status of the client. 6.0e Evidence of linking of clients with full range of benefits or entitlements. 6.0f Evidence of linking client with needed services such as: ▪ Medical ▪ Substance abuse ▪ Mental health ▪ Social services ▪ Financial ▪ Counseling ▪ Educational ▪ Housing ▪ Other support services	Specific information about a QA plan are not addressed.	Specific information about a QA plan are not addressed.	Specific information about a QA plan are not addressed.	S: A plan to monitor services is expected. S: The types of documents to monitor within each client file are outlined. W: As outlined, the QA plan outlines the types of documents to be reviewed but does not outline the key components of a QA plan. W: Activities focus on quality assurance instead of continuous quality improvement. W: The frequency for monitoring such items is not delineated. W: Plans to utilize data to improve services are not outlined.	Revise the requirements to focus on CQI vs. QA. Delineate the key components of a CQI plan. Outline the frequency for monitoring selected indicators. Delineate expectations on the use of data.

Column 1 **Baltimore EMA Standards**	*Column 2* **MA Standards**	*Column 3* **VDH Standards**	*Column 4* **NASW Standards**	*Column 5* **Strengths/Weaknesses**	*Column 6* **Recommendations**
6.0g A process for clients to evaluate the agency, staff and services.	Not addressed.	For consumers who self report services no longer necessary, an exit interview will be conducted.	Appropriate client feedback should be sought on services they received and that feedback should be incorporated in this process.	S: A process to solicit client feedback is required and is an expectation of HRSA. W: Information such as this should be documented for the agency and not in the individual client's chart.	None

Table 3. Comparison of Title I and Title II Standards

Column 1 **Baltimore EMA TI Standards**	*Column 2* **MD TII Standards**	*Column 3* **Strengths/Weaknesses**	*Column 4* **Recommendations**
1.0 Levels of Case Management **1.1 Intensive**			
1.1a Duration of relationship expected to last as long as program expectation.	No levels of case management are addressed. Levels of need are identified. There is reference to emergency versus non emergency needs only. Duration of relationship not addressed.	S: The standard is consistent with the intent of Ryan White funding to provide services through the entire life span of persons with HIV.	None
1.1b Significant involvement in coordinating services to consumer/client and/or family and household members.	Case manager will maintain regular contact at intervals agreed upon by the client and case manager in the initial assessment and periodic plan reviews.	S: Consumer involvement is delineated and is in accordance to the other standards. S: Solicitation of information and advice from clients is essential if case management is to address the real-life dilemmas faced by people with HIV.	None
1.1c. Problem solving spans medical, mental health, substance abuse, social services, and support services. Follow-up on referrals required.	Recognize the client concerns as the primary issue. Follow-up with referral sources is part of monitoring.	S: Identification of problem and development of a plan to resolve the issues are required. Follow-up on referrals is required. W: Does not recognize the client's concerns as the primary issues to be	Emphasize need to recognize client concerns as priority issues to address.

Column 1 **Baltimore EMA TI Standards**	*Column 2* **MD TII Standards**	*Column 3* **Strengths/Weaknesses**	*Column 4* **Recommendations**
		addressed.	
1.1d. Consumer/client will receive a minimum of one face-to-face contact per month from case manager. If the consumer/client does not follow through with scheduled appointments, the case manager will initiate contact.	Monitoring must be done at regular intervals which have been predetermined a the time of the plan of care and more depending on the client need.	S: The level and type of contact is clearly defined and more detailed than other standards.	None
1.1e. Each consumer will have an initial plan of care written up. This care plan will be arrived at by mutual agreement during the assessment phase of services. The plan must be completed within 2 months of the first interview. Written re-evaluation of the care plan will occur once every six months. The agency shall continue with current client plan for one year if the client's needs have not changed.	A care plan is developed and written in collaboration with the client and other members of the multidisciplinary team… and anyone involved in the client's case…with at least one face to face contact.	S: Time frames for development and re-evaluation of care plan by level of case management are clearly delineated.	None
1.2 Intermediate or Periodic			
1.2a. Duration of relationship expected to last as long as program expectation.	No levels of case management are addressed. Levels of need are identified. There is reference to emergency versus non emergency needs only. Duration of relationship not addressed.	S: The standard is consistent with the intent of Ryan White funding to provide services through the entire life span of person with HIV.	None
1.2b. Level of case manager's involvement in coordinating services to the consumer/client and or family and household members will be determined by the consumer's needs for interventions.	Monitoring must be done at regular intervals which have been predetermined a the time of the plan of care and more depending on the client need.	S: The standard ensures that the case manager will be involved in all phases of case management practice to the greatest extent possible.	None
1.2c. Problem solving spans medical, mental health, substance abuse, social services, and support services. Follow-up on referrals required.	Recognize the client concerns as the primary issue. Follow-up with referral sources is part of monitoring.	S: Identification of problem and development of a plan to resolve the issues are required. S: Follow-up on referrals is required. W: Does not recognize the client's concerns as the primary issues to be addressed.	Emphasize the need to recognize client concerns as priority issues to address.
1.2d. Contact will be initiated by the case manager or consumer at least every (3)	The level of need must be identified to determine or document the frequency of	S: The level and type of contact is clearly defined and more detailed than	None

Column 1 **Baltimore EMA TI Standards**	*Column 2* **MD TII Standards**	*Column 3* **Strengths/Weaknesses**	*Column 4* **Recommendations**
months and at least one face-to-face contact a year.	contact.	other standards.	
1.2e. Each consumer will have a written initial plan of care, which will be re-evaluated at least annually.	The level of need must be identified to determine or document the frequency of contact.	S: Specific time frames for contact are identified. W: W: Standard 2.6a indicates the plan must be evaluated every six months.	Resolve the discrepancy between the standards of care related to frequency of re-evaluation.
1.3 Limited or One-Time Intervention			
1.3a Clients receive a mini assessment specific to client identified problem; other issues and problems may be identified at this point. Intervention is documented.	A comprehensive psychosocial needs assessment (non-emergency) will be performed within six weeks of the client being identified as needing case management services.	S: A mechanism to assess needs for clients receiving Limited or One-Time Intervention is established. Such mechanisms are not described in the other standards.	None
1.3b Duration of relationship may be limited to specific issues.	Not addressed.	S: Flexibility of length of relationship is afforded based on the specific issues identified.	None
1.3c Problem solving limited to resource identification.	Not specifically addressed.	S: Scope of work related to problem solving has been limited to identification of resources.	None
1.3d Case manager is expected to have no more than 2 contacts. If more follow-ups are necessary within a 90-day period from the initial contact, the case manager will re-assess the level of case management for appropriateness.	The level of need must be identified to determine or document the frequency of contact.	S: The level of interaction is clearly defined. Similar levels of specificity are not outlined in other standards. W: Depending on how the level of service is communicated with the client, the definition could prevent clients from contacting case managers when there are real issues, if the clients may think they are "bothering" the case manager or not allowed to have more than 2 contacts.	None
1.3e No plan of care is necessary.	Not addressed.	S: The lack of a plan of care reduces paperwork for case mangers. W: Without documentation of issues, resources provided and resolutions, there is no quality assurance process to support this form of case management.	Outline requirements for documenting services provided.
2.0 PRACTICE GUIDELINES			

Column 1 **Baltimore EMA TI Standards**	*Column 2* **MD TII Standards**	*Column 3* **Strengths/Weaknesses**	*Column 4* **Recommendations**
2.1 Consumer/Client Identification			
2.1a Screen all individuals to determine HIV status and appropriateness for agency services.	Verification of the client's HIV status and eligibility for services shall be recorded in the client record.	S: Standards are consistent.	None
2.1b Make suitable referrals for persons not appropriate for agency's case management services.	Not addressed.	S: Recognizes that case management services may not be appropriate for the client's needs and that other referrals may be needed.	None
2.1c Assess individuals in crisis to determine what agency interventions are appropriate.	Not addressed.	S: Plans to assess persons in crisis are specifically addressed.	Maintain this level of detail in standards of care.
2.1d Assign a case manager to eligible clients at time of initial contact.	The individual performing the assessment will be the client's case manager unless the client requests a change.	S: Clients are immediately linked with a case manager at the initial contact. W. Identification of a case manager prior to an intake does not provide an opportunity to match the case manager to the client and their needs.	Allow more flexibility as to when case manager can be assigned, but no later than completion of the intake and screening. Define the time frame for completion of the screening process.
2.2 Intake			
2.2a Agency shall complete an initial assessment on eligible clients at time of intake; collecting all information outlined on agency's intake forms.	A comprehensive psychosocial needs assessment (non-emergency) will be performed within six weeks of the client being identified as needing case management services. Areas to be covered: medical, psychiatric, substance abuse history,…nutritional status, living situation…health care coverage,…income, social support…	W: Timeframes for completion of the intake process is not defined.	Define the time frame for completion of the intake process. *Note:* Intake and Psychosocial Needs Assessment/Resource Identification are both labeled Standard 2.2
2.2b Clients presenting with emergency needs will have those needs addressed by conclusion of the intake appointment.	Not addressed.	S: Emergency needs of client are to be handled as priorities.	None
2.2c Client will be seen for first case management appointment within 5 working days after assignment to a case manager or 10 working days if an off-site visit is required.	Not addressed.	S: Time frame for initial appointment is clearly delineated.	None

Column 1 **Baltimore EMA TI Standards**	*Column 2* **MD TII Standards**	*Column 3* **Strengths/Weaknesses**	*Column 4* **Recommendations**
2.2d Agency shall assist the client in identifying and making an appointment with a medical provider for those not already connected to a primary medical care provider. *Client is to schedule their own appointment if able.*	Case manager and or provider agency should make initial contact to ensure that medical support referrals were completed…	S: Linkages to primary care are specified and directly correspond to the intent of Ryan White CARE Act.	None
2.2 Psychosocial Needs Assessment /Resource Identification			
2.2a Case manager shall complete a comprehensive written psychosocial needs assessment for each client within 30 days or by conclusion of 3rd case management appointment, whichever comes first. Needs assessment shall include a medical and psychosocial history and be included in client's record.	A comprehensive psychosocial needs assessment (nonemergency) will be performed within six weeks of the client being identified as needing case management services. The results of the assessment must be documented in the client record.	S: Standards are relatively consistent with slight differences in time frames.	None *Note:* Intake and Psychosocial Needs Assessment/Resource Identification are both labeled Standard 2.2
2.2b Case manager shall ensure that client chart contains written indication that current needs have been discussed and/or identified at time of needs assessment. Case manager should review the listed areas of consumer/client needs when performing needs assessment.	Every direct or indirect contact, including reassessment of progress of implementation of the care plan is to be documented in the client's permanent record. A comprehensive psychosocial needs assessment (nonemergency) will be performed within six weeks of the client being identified as needing case management services. Areas to be covered: medical, psychiatric, substance abuse history,…nutritional status, living situation…health care coverage,…income, social support…	S: Standards are consistent.	None
2.2c. Agency should ensure that a mini-assessment specific to the client-identified problem is completed for any individual requesting limited/one time intervention.	No mini-assessments are addressed. A comprehensive psychosocial needs assessment (nonemergency) will be performed within six weeks of the client being identified	S: A mechanism to assess needs for clients receiving Limited to One-Time Intervention is established. S: Mini-assessments provide an additional opportunity for case managers to determine other needs and provide specific services.	None

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2.3 Development of Client Plan of Care			
2.3a Case manager shall, with active participation of client, identify which needs are to be addressed through the development of goals and objectives with established time frames. Incorporate written objectives and goals into the plan of care, which is a permanent part of the client chart. Development of the plan of care started by the 3rd case management visit or within 30 working days after assignment to case manager.	A care plan is developed and written in collaboration with the client and other members of the multidisciplinary team. Plan will contain established goals, objectives, and outcomes regarding the client's health and psychosocial status. No time frames for development of plan are provided.	S: Client involvement in the development of the care plan is expected in both standards. S: Time frame for development of plan of care is delineated.	None
2.3b Agency, together with client, shall identify appropriate resources needed to attain stated goals and objectives. Resources shall be written into plan of care.	Outline a specific set of services to meet the plan of care.	S: Identification of resources is not the sole responsibility of the case manager. Empowerment of the client toward self-sufficiency is a key goal of case management. Having the client identify resources helps to begin that process. S: Documentation of resources identified shall be written in plan of care.	None
2.3c Agency shall provide written verification that client is in agreement or disagreement with goals and objectives contained in plan of care.	Ensure that client understands and agrees with the plan of care as evidenced by the client's signature.	S: Standards are consistent.	
2.4 Implementation and Coordination of Client Plan			
2.4a Case manager will proactively attempt to contact client after the development of the plan to implement those parts that were not executed at the time of plan development. Plan will establish priorities among the identified needs.	Monitoring and evaluating the care plan includes reviewing and checking the status of each activity outlined in the plan of care. Evaluation of the care plan in collaboration with the client needs to be conducted at least every 6 months, with input from any members of the multidisciplinary team….	S: Follow-up with clients is outlined. S: Needs will be prioritized in order of importance. W: The time frame for contacting the client is not defined.	Define time frames for contacting clients after care plans have been developed.
2.4b Case manager shall advise the client on	The case manger will assist the client with	S: Clients are encouraged to coordinate	Include a provision for case

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making arrangements with service providers selected and on ways of gaining access to those services.	each action plan to reach the goals outlined in the plan of care.	access to services once they have been provided with appropriate information about resources. W: This standard does not take into account clients who are unable to navigate systems and follow through on assigned tasks.	managers to access systems for clients who can not successfully access services on their own.
2.4c Case manager shall document in writing all referrals and outcomes initiated and or completed as they relate to the plan of care. Any corresponding actions initiated by the client/other identified people and the outcomes resulting from these actions shall be incorporated into the client record.	Every direct or indirect contact, including reassessment of progress of implementation of the care plan is to be documented in the client's permanent record.	S: Standards are consistent. W: The time frame for follow-up on referrals is not defined.	Define the time frame for follow-up on referrals.
2.4d Case manager shall be in communication with the client as follows: **Intensive:** A minimum 1 contact per month and 1 face to face contact every 6 months. **Intermediate:** A minimum of 1 contact every 3 months or 1 face to face contact every year.	Not addressed.	S: The number of required contacts are clearly defined for intensive and intermediate service. W: Though included in Standard 2.5a, the level of contact for Limited services is not defined.	Define the level of contact for limited case management services.
2.5 Monitoring the Client Plan			
2.5a Documentation of the monitoring process shall be recorded in the client record. Monitoring shall occur at a minimum of the following: **Intensive:** A minimum 1 contact per month or 1 face to face contact every 6 months. **Intermediate/periodic:** A minimum of 1 contact every 3 months (1 face to face contact every year). **Limited**: Case manager involved in no more than 2 contacts limited to particular issues.	Evaluation of the care plan in collaboration with the client needs to be conducted at least every 6 months, with input from any members of the multidisciplinary team…. No other time frames are provided.	S: The frequency of contact and documentation is clearly delineated by level of service. Other standards do not contain this level of specificity. S: Written documentation allows any case manager to assist the client with future needs.	None

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2.5a(1) If a client cannot be located after several attempts to reach by telephone and/or letter, for 2 months, then a referral is made to case finding to assist in locating the client.	Case manager attempts to reach the "lost to follow-up" client over six months with at least three attempts to contact the client.	S: Specific parameters define when a client should be referred for case finding.	None
2.5a(2) If the client cannot be located within 90 days, the case management record is moved to inactive status.	Case manager attempts to reach the lost to follow-up client over six months with at least three attempts to contact the client.	S: Specific time frames for moving clients to inactive status are outlined. No other standard offers this level of specificity.	None
2.5a(3) At end of year, if there is no contact, then the case management record is closed (intensive and intermediate)	Case manager attempts to reach the lost to follow-up client over six months with at least three attempts to contact the client.	S: The time frame for closing a file due to lack of contact is clearly delineated. S: Sufficient time is allowed before a record is closed. This allows clients to be reinstated as needed, which is particularly important given the high number of substance users and those with mental health issues.	None
2.5b Case manager shall monitor the services provided and service delivery to verity that services are being received and are sufficient in quality and quantity.	Evaluation of the care plan in collaboration with the client needs to be conducted at least every 6 months, with input from any members of the multidisciplinary team….	S: An expectation is made that services will be monitored for receipt, quality and quantity. W: The frequency and process for monitoring services are not specified.	Outline the frequency and requirements for monitoring services.
2.5c Case manager shall provide written documentation of any difficulties encountered in achieving the goals and objectives and provide written strategies for resolving these difficulties.	Every direct or indirect contact, including reassessment of progress of implementation of the care plan is to be documented in the client's permanent record.	S: The required documentation addresses difficulties encountered and strategies taken for resolution. This standard provides a reminder of the importance of consistent documentation for case files.	None
2.5d Case manager shall make available professional supervision or consultation to all case managers while plan of care is being monitored. Minimum of 1 hr. of formal supervision/mo. is required.	General supervision is addressed, but not specific to care plans.	S: A minimum level of supervision required is clearly outlined. W: The minimum level of supervision may not be sufficient for less experienced case managers. W: Supervision requirements are delineated only while the care plan is	Additional supervision requirements should be delineated for case managers with limited experience or education. Supervision requirements

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		being monitored.	should be designated for all phases of the case management process.
2.6 Re-evaluation of the Plan of Care			
2.6a Each agency shall assess the client records a minimum of every 6 months to determine the client's status and progress and whether any revision is needed in the care plan or in the provision of services. Record review in progress notes. Record review may be done by case manager, supervisor, peer review or formal audit.	Case managers should examine the actual service delivery against the plan of care. No time frames are provided.	S: The time frame for re-evaluation of the plan of care is defined. This level of specificity is not outlined in 2 of the 3 standards. S: Six months is a reasonable amount of time to resolve client issues, and determine the status of others. W: Standard 1.2e indicates plans for clients receiving intermediate or periodic case management services shall be re-assessed every year.	Resolve the discrepancy betwee standards of care related to frequ re-evaluation.
2.6b The case manager shall develop with the active participation of the client, new goals and objectives if the needs have changed since the previous needs assessment.	A care plan is developed and written in collaboration with the client and other members of the multidisciplinary team…. Plan will contain established goals, objectives, and outcomes regarding the client's health and psychosocial status.	S: Consumer involvement is expected and outlined in both standards. S: This standard is a reminder for case managers to take a proactive approach to determining client needs.	None
2.7 Closure			
2.7a Prior to closure (with the exception of death), the agency shall attempt to inform the client of the re-entry requirements into the system, and make explicit what case closing means to the client.	A written policy must exist for case closure…and the client be apprised of the right to re-enter services at a later time.	S: Clients are given the opportunity to return to case management. S: This standard provides a protection for the case manager and the agency against clients who will be unable to remember how, why or when case management services where terminated. This also allows time for reinstatement. W: Requirements for documenting	Outline requirements for documenting attempts to reach the client.

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		attempts to reach the client are not delineated.	
2.7b The agency shall close a client file according to the procedures established by the agency.	A written policy must exist for case closure.	S: Closure of client files are deferred to agency procedures. W: Beyond lack of contact with client and death, examples of reasons for closure of files are not provided. W: Requirements for documenting reasons for closing files are not delineated.	Provide additional examples of reasons for terminating services and closing files. Outline requirements for documenting reasons for closing files.
2.7c Adults records must be maintained for a minimum of 10 years after last entry. Records of children under 19 yrs. Must be archived until child reaches 24 yrs. or 6 yrs. after death.	Not addressed.	S: Record keeping and file maintenance time frames are clearly outlined.	None
3.0 LICENSING			
3.0a Agency will show evidence of being licensed by an appropriate body.	Title II and State funded service providers, facilities and personnel will possess documentation of being licensed/certified by an appropriate (where applicable).	S: Standards are consistent.	None
3.0b Licenses must be current and available.	Title II and State funded service providers, facilities and personnel will possess documentation of being licensed/certified by an appropriate (where applicable).	S: Standards are consistent.	None
3.0c Where applicable, staff will have licenses that are current and appropriate for providing case management services.	Title II and State funded service providers, facilities and personnel will possess documentation of being licensed/certified by an appropriate (where applicable). Professional staff will possess current licensure by the State of Maryland. Licensed RN or licensed social worker with 1 year experience are minimum qualifications for case managers. Non-licensed staff or volunteers will receive professional supervision.	S: Requirements to maintain current licensure are consistent across standards. W: Discipline-specific requirements for serving as case managers are not delineated nor are standard educational requirements outlined.	Explore the feasibility of designating minimum education requirements or discipline-specific requirements for individuals to serve as case managers.
4.0 TRAINING AND SUPERVISION			
4.0a Agency will maintain documentation that	Supervision of case manager shall be RN or	S: Discipline-specific requirements of	Delineate the minimum years of

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demonstrates case management services are provided directly by or under supervision of LCSW and/or RN case manager.	license-certified social worker with minimum of 3 years experience. Non-licensed staff or volunteers will receive professional supervision.	supervisor are outlined and consistent between the standards. W: The years of experience required to serve as a supervisor are not delineated.	experience required to serve as a supervisor.
4.0b Maintain documentation for staff education, given or taken, on pertinent HIV/AIDS topics.	Documentation of education is not addressed.	S: Documentation of continuing education activities are required. W: Minimum training requirements are not outlined.	Outline the annual minimum training requirements.
4.0c Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.	Orientation, on-going training programs and in-service presentations shall be provided to staff on topics relative to HIV services.	S: Continuing education is encouraged and are critical for all staff to remain knowledgeable about HIV-specific issues. W: Minimum training requirements are not outlined.	Outline minimum training requirements.
4.0d Create a system that regularly updates staff resource information network of available services for PLWH/A.	Not addressed.	S: A system to keep staff informed about available resources is expected.	None
5.0 CLIENT RIGHTS AND RESPONSIBILITIES			
5.0a Have a written agency policy on client confidentiality.	Assurances must be given to all clients seeking services regarding confidentiality of the information given to service providers…Requirement of a written policy is not delineated.	S: Specifies that a written policy is required. S: Intent of both standards are consistent.	None
5.0b Have a statement signed by the client that states the policies were explained. Eligibility criteria and available services should be given to each client requesting services.	The client record contains a signed and dated consent for services…the consent form describes services offered at the agency. The client shall be given a copy of the signed consent form. At the initiation of services, all clients receiving Title II services must receive a copy of a PWA Bill of Rights… grievance policy and an explanation of any client responsibilities. The client must receive a copy of the standards for the specific service received. This includes the universal standards. Eligibility criteria are	S: Client signatures are required. S: Empowerment of clients begins with ensuring they are aware of all policies and procedures for service delivery. W: A copy of the confidentiality statement is not required to be given to the client. W: Eligibility criteria are not outlined.	Provide a copy of the statement to the client. Delineate eligibility criteria.

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	outlined.		
5.0c Have a system for ensuring that case records are protected and secured.	Records of services to clients must b stored in a secure filing system. Computerized records are password protected and backed up at least weekly. There is documentation of when and by whom files are removed from the system.	S: A system for ensuring case records are secure is required. W: Specific requirements for protecting and securing case records are not outlined.	Outline the specific requirements of record keeping.
5.0d Have a written, signed consent for release of information that pertains to establishing eligibility for agency services.	The client record contains a signed consent for release of information…must contain…kinds of information that will be shared and with whom…The client shall be given a copy of the signed consent form. The release form must be signed once each year.	S: Standards are consistent. S: This standards ensures information is not released without client authorization. W: A new form is not required each year.	Obtain new release forms on an annual basis.
5.0e Have a written grievance procedure.	At the initiation of services, all clients receiving Title II services must receive a copy of a PWA Bill of Rights… grievance policy and an explanation of any client responsibilities. The client must receive a copy of the standards for the specific service received. This includes the universal standards.	S: Establishes a formal system for clients to grieve issues. S: Standard is in accordance with HRSA's expectations. W: The key components of a grievance procedure are not outlined.	Outline the key components that should be included in the grievance procedure, e.g. steps to file a grievance, how the grievance will be handled.
5.0f Have a statement of consumer/client rights as well as responsibilities of agency expectations of each client.	At the initiation of services, all clients receiving Title II services must receive a copy of a PWA Bill of Rights… grievance policy and an explanation of any client responsibilities. The client must receive a copy of the standards for the specific service received. This includes the universal standards.	S: Standards are consistent.	None
5.0g Have a statement that outlines process for both voluntary and involuntary disengagement from services.	A written policy must exist for case closure…and the client be apprised of the right to re-enter services at a later time.	S: All policies related to case management should be in writing, including discharge criteria. W: Clients are not required to sign the statement.	Request clients to sign the statement.
6.0 Quality Assurance			

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The quality assurance plan, contained in the client file, should include the following: 6.0a A mutually established plan of care. 6.0b A full needs assessment with psychosocial and medical needs described. 6.0c Documentation of services delivered, referrals made, advocacy efforts initiated to address needs as presented in care plan. 6.0d Evidence that the plan of care was reviewed at least 6 months and when appropriate modified according to the medical status of the client. 6.0e Evidence of linking of clients with full range of benefits or entitlements. 6.0f Evidence of linking client with needed services such as: ▪ Medical ▪ Substance abuse ▪ Mental health ▪ Social services ▪ Financial ▪ Counseling ▪ Educational ▪ Housing ▪ Other support services 6.0g A process for clients to evaluate the agency, staff and services.	The agency will have a Quality Assurance/Improvement program that will provide an overall mechanism for assessing the quality, appropriateness and effectiveness of services provided. This may include, but is not limited to: peer review, record review, utilization review, client satisfaction surveys, and an Action Plan. The Action Plan will be formulated to document corrective actions and improvement in outcomes. Decisions will be based on best practices consistent with national and State standards.	S: A plan to monitor services is expected. S: The types of documents to monitor within each client file are outlined. W: As outlined, the QA plan outlines the types of documents to be reviewed but does not outline the key components of a QA plan. W: Activities focus on quality assurance instead of continuous quality improvement. W: The frequency for monitoring such items is not delineated. W: Plans to utilize data to improve services are not outlined.	Revise the requirements to focus on CQI vs. Q A. Delineate the key components of a CQI plan. Outline the frequency for monitoring selected indicators. Delineate expectations on the use of data.